consisting of stavudine, lamivudine, and efavirenz, was started 14 days after initiation of antimycobacterial therapy. The skin lesions resolved completely.

Seven weeks later he was readmitted with fever. Examination was unremarkable. Investigations showed total white count 18.2 × 10^9/l, with monocytes 15.2 × 10^9/l; CD4 count 70 cells × 10^6/l, and HIV viral load 10 700 copies/ml. Five days after admission new painful skin lesions appeared on his arms and legs. These were tender, erythematous, and had a pustular centre (fig 1B). The monocyte count peaked at 43.2×10^9/l on the sixth day. Aspiration of pus from a skin lesion revealed multiple AFB; MAC was subsequently cultured. Antimycobacterial therapy was intensified with addition of rifabutin, intravenous amikacin, and prednisolone (60 mg once daily reducing to zero over 14 days). The skin lesions resolved completely over 10 days as did the neutrophilia and monocytosis. Amikacin was stopped after 2 weeks. The patient remains well 8 months later.

The recurrence of disseminated MAC infection in our patient illustrates dramatically the impact of HAART on the clinical course of this disease. The highly inflammatory skin lesions that developed occurred at a higher CD4 count after HAART and differed significantly from the indolent lesions (more typical of cutaneous MAC infection in patients with advanced HIV disease) with which he originally presented. The appearances of these lesions together with the contemporaneous leukaemoid response suggest a different immunopathological process.[4 5] This case illustrates the increasingly protean manifestations of immune reconstitution disease. Clinicians caring for patients with previously documented MAC should be aware of this phenomenon if HAART is commenced.

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Detection or treatment: which outcome measure?

EDITOR,—The report by Rogstad *et al*[1] is a timely description of the problems associated with the management of patients diagnosed with genital chlamydial infection within and between established healthcare settings. The inappropriate or inadequate treatment, low rates of partner notification, and lack of referral to genitourinary medicine (GUM) clinic described were similar to the observations made in two recent studies. An investigation in Merseyside family planning clinics (FPC) showed that of 80 infected patients identified (n = 958) only 34% were treated within 1 month of diagnosis, 24% had no proof of treatment, and 13% never found out they were infected.[2] Similarly, a study of 112 women diagnosed with *Chlamydia trachomatis* attending FPCs showed that only 48% were known to have been treated 3 months after the test had been carried out.[3] If diagnosis does not result in immediate treatment, patients can be lost to follow up. In turn, this can result in poor rates of partner notification, an increased likelihood of further transmission, a reduction in the impact of testing on disease incidence, and an increased risk of complications. In GUM clinics, diagnosis generally results in treatment and consequently surveillance data derived from this setting, the KC60 dataset, can be used as a measure of treatment success. In contrast, the above studies suggest that a proportion of diagnoses made in primary care may not be treated. This questions the validity of using diagnosed infection as an outcome measure for evaluating sexual health intervention in primary care. It also emphasises the significant role of clinical audit in the improvement of the quality of patient management.

Ultimately the effectiveness of intervention should be measured in terms of a reduced prevalence of pelvic inflammatory disease and associated sequelae.[4] However, other more pragmatic outcome measures may need to be used. The UK NHS *C trachomatis* screening pilot is evaluating the feasibility and acceptability of opportunistic screening in primary and secondary healthcare settings in two health authorities.[5] Three of the primary outcome measures that are being evaluated are the number of positive diagnoses, the proportion of the positive diagnoses treated, and the rate of patient or provider led partner notification. In the pilot, patient management has been improved by recalling positive patients to a centralised community office staffed by GUM health advisers. Preliminary data indicate that out of 900 positive patients identified through the Wirral arm of the pilot, treatment was not confirmed for 40 (4.4%) patients. Separate studies in Liverpool are also evaluating how patient management could be enhanced by GUM health advisers working in outreach sessions in a community FPC (AMCW) and a department of obstetrics and gynaecology (T Gleave, submitted to *British Journal of Family Planning*). Results from these studies will provide further evidence to guide the development of patient management and the outcome measures that could be used to assess future intervention strategies.

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Obituaries

EDITOR,—The obituaries of three physicians, Ambrose King, Eric Dunlop, and David Oriel, appeared in quick succession in your columns.

By the time I started training in venereology, as it was then called (not a bad name incidentally because it means the science of the act of love which encompasses STIs, colposcopy, HIV disease, and sexual dysfunction) at the Whitechapel Clinic of the London Hospital in 1973 Ambrose King had already left. However, the clinic still sparkled (not physically you understand) from his inspirational radiance and he was spoken of in hushed, reverential tones.

Eric Dunlop was the senior physician at that time. To a very junior doctor he was literally an awe inspiring figure. By today's standards he did not educate or teach. Rather you were well aware that he had laid a "golden egg" and that there was a touch of colour and brilliance in his research work and lectures. I was taught basic day to day venereology by the senior charge nurses at that department. Eric Dunlop's meticulousness was legendary. We took nine specimens from each woman to screen for *Chlamydia trachomatis* (including three cervical curettings) and a cervical biopsy. The purpose built Dunlop-Jones male urethral curette was a most efficient method of obtaining chlamydial material, although its contemporaneous thalamic overstimulation did not endear it to the patients. This meticulousness transferred itself to one's own attitude to research, and many of us also aspired to achieve Eric Dunlop's larger than life persona and facility for developing newer ideas (never really worked for me!).

I later worked for David Oriel. He made advances by quietly yet relentlessly pushing away at the broad front of research and clinical medicine. He was attracted by many of the sensible, practical, therapeutic approaches of our American colleagues—for example, benzathine penicillin for syphilis, doxycycline for chlamydia, which were far from routinely practised in the United Kingdom at that time. David Oriel also insisted on each set of clinical notes being audited on a daily basis. This was in 1978, well before clinical audit became routine.

Both Eric Dunlop and David Oriel were wholly generous and encouraging to a young

physician whose clinical practice, research ideas, and papers didn't always make a lot of sense.

I grieve for their loss but I am grateful that I worked for these two great venereologists.

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BOOK REVIEWS

The New Hite Report. Shere Hite. £12.99; Pp 667. London: Hamlyn, 2000. ISBN 0-600-60116-1.

This is a follow up on the author's 1976 *Report on Female Sexuality*. It confirms the findings of her earlier report on American women and includes a "postscript" which reports similar findings in UK, Australian, and New Zealand women. The emphasis is on orgasm frequency.

In the American part of the study three versions of a questionnaire (labelled I, II, and III) augment the earlier 1972–6 study (labelled IV). Altogether, the number of questionnaires distributed was 100 000 with 3019 returned. The number of questionnaires I, II, and III returned was 1844. Replies received from UK, Australian, and New Zealand women to questionnaire IV numbered 511. The author claims that, especially, questionnaires I, II, and III give a true representation of women of all ages and occupations. The figures are presented partly in the text and by detailed appendices. The text provides detailed individual quotes in abundance on all aspects of female sexuality and orgasm.

In brief, there is little new to report. Masturbation remains the surest source of orgasms both single and multiple. Orgasm "rarely" occurs during intercourse without additional stimulation. Most women were willing to accept sex with a man even if she didn't often have an orgasm with him. Lesbianism was a regular source of orgasm for a few women but many more would "like to try" such a relationship.

From the answers to questions and the personal views presented by women, it is clear that the majority support Hite's view that a "sexual revolution" is needed. They see the way forward as through greater openness. There is a need to destroy double standards—for example, the concept that sexy women, in contrast with sexy men, are not respectable. In addition, it is clear women would like it noted that they would appreciate the pattern and definition of sex to include greater diversity. Sexual intercourse on its own is not enough for many. Greater diversity is called for. In other words women's desires and needs, not least in achieving orgasm more regularly, need to be taken into account.

By way of summary, Hite calls for greater dissemination of data regarding the anatomical basis and the physiology of female orgasm with emphasis on the role of the clitoris. In her revolutionary terms she sees orgasm as a metaphor for women's power in society.

The findings confirm those of Freud, Kinsey *et al* as well as Masters and Johnson and make it clear that men not only need to take the clitoris seriously but to ensure that its function is more regularly fulfilled whatever the form of sexual congress.

R S MORTON

Management of Antimicrobials in Infectious Diseases: Impact of Antibiotic Resistance. Edited by Arch G Mainous III, Glaire Pomeroy. Pp 350; $99.50. New Jersey: Humana Press, 2000. ISBN 0-896-03821-1.

Over the years, many books on the use of antimicrobials in the treatment of infectious disease have been written. Although few of these books have a subtitle implying that resistance will be specifically dealt with (as with this book), most of them by necessity write about this topic. I approached this book with a degree of cynicism, expecting to find the same tales retold in the same formulaic way. The first part of the book was not what I expected and I was pleasantly surprised. The first seven chapters dealt with the science of resistance generally, and then with specific examples, in a way that was informative and relevant to many clinicians. These early chapters also information on epidemiology, public health measures, and vaccination that are relevant to managing the problems of resistant organisms. Although this is a multi-author book, there seemed to be more consistency in approach and writing in these early chapters than those found later. The latter part of the book was little more than the systems based summary of antimicrobial use found in so many books.

As is to be expected with a book written by American authors, there are differences in practice from that in the United Kingdom: recommendations for treatment of community acquired pneumonia differ from those of the British Thoracic Society; recommendations for the treatment of infective endocarditis differ from those of the BSAC Working Party. Although generic drugs, some of these are different (although comparable) from those we would use in the United Kingdom. The authors frequently recommend the use of trimethoprim-sulfamethoxazole; because of the risk of sulphonamide toxicity, the CSM only recommends the use of this combination for specific indications in the United Kingdom. In the chapter on meningitis the authors do not recommend the immediate use of penicillin upon clinical suspicion (UK guidance). The controversy of use of antibiotics in the treatment of infective diarrhoea is not discussed. Most importantly, the adverse effects of using antibiotics in shigellosis in children and EHEC infection are not mentioned.

The chapters on the treatment of sexually transmitted infections and HIV are short for a specialist reader, and there really should have been a separate chapter on hepatitis. I doubt there is much in this book that the established GUM clinician or scientist will find helpful. The trainee GUM physician may be confused or misled.

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NOTICES

International Herpes Alliance and International Herpes Management Forum
The International Herpes Alliance has introduced a website (www.herpesalliance.org) from which can be downloaded patient information leaflets. Its sister organisation the International Herpes Management Forum (website: www.IHMF.org) has launched new guidelines on the management of herpesvirus infections in pregnancy at the 9th International Congress on Infectious Disease (ICID) in Buenos Aires.

Pan-American Health Organization, regional office of the World Health Organization
A catalogue of publications is available online (www.paho.org). The monthly journal of PAHO, the Pan American Journal of Public Health, is also available (subscriptions: pubsvc@tsp.sheridan.com).

MSSVD Course in STIs and HIV, Spring 2001, to be held at the Institute for Materials, 1 Carlton House Terrace, London, UK
This modular course runs twice a year and is aimed predominantly at SpRs, NCCGs, and practitioners from overseas. It leads to the diploma in genitourinary medicine of the Society of Apothecaries but participants can complete the course without taking the examination. The course aims to provide participants with an overview of current practice in GUM, sexual health, STIs, and HIV infection and related areas, focusing particularly on practice in the UK, but within the context of the worldwide epidemic of STIs.

Module 2, 30 April–1 May 1, Viral infections other than HIV; Module 3, 2–4 May, HIV infection. Further details: Sue Bird, MSSVD Course Secretariat, PO Box 77, East Horsley, Surrey KT24 5YP, UK

6th European Conference on Experimental AIDS Research (ECEAR 2001), 23–26 June 2001, Heriot-Watt University, Edinburgh, UK
Further details: ECEAR 2001 Conference Secretary, Division of Retrovirology, NIBSC, Blanche Lane, South Mimms, Potters Bar, Herts, EN6 3QG, UK.

International Congress of Sexually Transmitted Infections, 24–27 June 2001, Berlin, Germany
Further details: Congress Partner GmbH, Krausenstrasse 63, D-10117, Berlin, Germany (tel: +49-30-204 500 41; fax: +49-30-204 500 42; email: berlin@cpb.de).

1st Asia Pacific Forum on Quality Improvement in Health Care
The 1st Asia Pacific Forum on Quality Improvement in Health Care will be held from 19–21 September 2001 in Sydney, Australia. Presented by the BMJ Publishing Group (London, UK) and Institute for Healthcare Improvement (Boston, USA), with the support of the Commonweatlh Department of Health and Aged Care (Australia), Safety and